PEE DEE HEARING CENTER

PATIENT INTAKE FORM

Today's Date _____

Preferred Name _____

Patient's Name _____ Date of Birth _____ Gender Male Female

Address _____ City _____ State _____ Zip _____

Main Phone #_____ ☐ OK to Text work cell home Secondary Phone # _____ work cell home

Email _____ Employer/School _____ ☐ Past ☐ Present

Marital Status ☐ Single ☐ Married ☐ Widowed Name of Spouse _____

Name of Observing Party _____ Relationship _____

Name of Family Physician _____

Permission to release a copy of test information to family physician ☐ Yes ☐ No

Preferred Language_____ Please specify your ethnicity from the section below

Caucasian African-American Latino/Hispanic Asian Native American Native Hawaiian/Pacific Islander Other/Unknown Prefer not to say

How did you hear about us? ☐ Mail ☐ Internet ☐ Physician ☐ Insurance ☐ Friend ☐ TV

☐ Other _____

Insurance Information

Primary

Insurer Name _____ Insurer Phone_____

Insurance ID No. _____ Insurance Group No._____

Secondary

Insurer Name _____ Insurer Phone_____

Insurance ID No. _____ Insurance Group No._____

Other _____

Patient Authorizations

Insurance & Financial Authorizations: I authorize the release of any information by Pee Dee Hearing Center to determine Insurance benefits and assignment of benefits for payment of service provide to me. I request that my insurance carrier make payment to Pee Dee Hearing Center. I understand that not all office services and cost of an aid are covered by my insurance and that any unpaid balance not covered by my policy will be payable by me. I hereby agree to the terms of payment as discussed at the time of services are rendered and in accordance with Pee Dee Hearing Center Audiology's Insurance policy. Refunds from service charge on a credit card will be returned to the same credit card.

Mail/Email Authorization: I authorize Pee Dee Hearing Center to contact me via mailing, phone, text and email addresses given above. I understand my information will never be sold; however, I may receive future promotional materials from Pee Dee Hearing Center, including information from third parties' companies.

Treatment Authorization: I hereby give Pee Dee Hearing Center consent for audiological treatment deemed advisable & necessary in the diagnosis and treatment of my hearing condition.

Medical Records Authorization: I authorize the release of medical records information to 1) the above-name insurance companies 2) any physician who has participated in my health care, and 3) to any physician who I may subsequently be referred to.

Please list Emergency contact info below:

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

Patient Signature or Legal Custodian _____ Date: _____

PEE DEE HEARING CENTER

Acknowledgement & Request of Privacy Practice

By signing below, I acknowledge that I have been given the option to request a copy of the PEE DEE HEARING CENTER notice of Privacy Practices.
I understand that my health information may be used and disclosed by the PDHC. I understand that I may obtain access and control this information.

_____ **YES** I would like a copy of the **PDHC** Privacy Practices

_____ **NO** I would NOT like a copy of the **PDHC** Privacy Practices

Please list who you give permission to contact us and have access to your pertinent medical information below:

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

_____
Print Name of Patient/ Guardian/Care Giver

_____ Date _____
Signature of Patient/ Guardian/Care taker